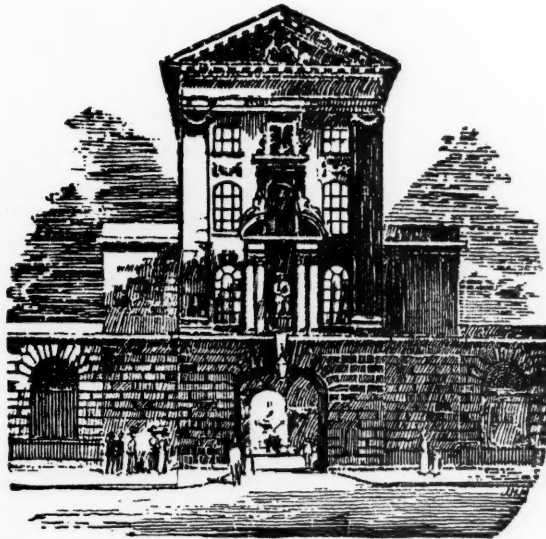


ST BARTHOLOMEW'S HOSPITAL JOURNAL

Medical Lib.



VOL. XXXV.—No. 5.

FEBRUARY, 1928.

[PRICE NINEPENCE.]

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"Æquam memento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

JOURNAL.

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CALENDAR.

- Wed., Feb. 1.—Surgery. Clinical Lecture by Sir C. Gordon-Watson.
- Fri., " 3.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
Medicine. Clinical Lecture by Dr. Langdon Brown.
- Sat., " 4.—Hockey Match v. Christ Church, Oxford. Home.
Rugby Match v. Devonport Services. Home.
Association Match v. Old Cholmelians. Away.
- Mon., " 6.—Special Subject. Clinical Lecture by Mr. Rose.
- Tues., " 7.—Prof. Fraser and Prof. Gask on duty.
- Wed., " 8.—Surgery. Clinical Lecture by Mr. L. B. Rawling.
Hockey Match v. Mill Hill School. Away.
- Fri., " 10.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
- Sat., " 11.—Rugby Match v. Pontypool. Home.
Hockey Match v. R.M.C., Sandhurst. Away.
Association Match v. Emmanuel College, Cambridge. Away.
- Mon., " 13.—Special Subject. Clinical Lecture by Mr. Elmslie.
- Tues., " 14.—Sir Percival Hartley and Mr. L. B. Rawling on duty.
Cup Tie. Rugby Match v. Winner of St. Mary's v. St. Thomas's.
- Wed., " 15.—Surgery. Clinical Lecture by Mr. L. B. Rawling.
- Fri., " 17.—Sir Thomas Horder and Sir C. Gordon-Watson on duty.
- Sat., " 18.—Association Match v. Old Bradfieldians. Home.
Rugby Match v. O.M.T. Away.
Hockey Match v. Old Uppinghamians. Home.
- Mon., " 20.—Special Subject. Clinical Lecture by Mr. Elmslie.
Last day for receiving matter for the March issue of the Journal.
- Tues., " 21.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
- Wed., " 22.—Surgery. Clinical Lecture by Sir C. Gordon-Watson.
Hockey Match v. Epsom. Home.
- Thurs., " 23.—Semi-final of the Rugby Football Cup Tie.
- Fri., " 24.—Prof. Fraser and Prof. Gask on duty.
Medicine. Clinical Lecture by Sir Percival Hartley.
- Sat., " 25.—Rugby Match v. Glamorgan Wanderers. Away.
Association Match v. Keble College, Oxford. Home.
- Mon., " 27.—Special Subject. Clinical Lecture by Mr. Scott.
- Tues., " 28.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
- Wed., " 29.—Surgery. Clinical Lecture by Mr. Harold Wilson.

EDITORIAL.



R. McADAM ECCLES has been a notable figure at the Hospital for so long that it is difficult to appreciate that he has actually left us. That he has retired at 60 is a striking example of that conscientious honesty which he carries into the smallest details of his practice, and it is a powerful argument in favour of one of his maxims—the reduction of the age-limit.

As a member of the Council of the Royal College of Surgeons and of the B.M.A. with the Chairmanship of the Hospital Committee added to the pressure of his private work, to which he is anxious to devote more time, the absence of Hospital routine will probably be very welcome to him.

At the dinner on January 10th, given to Mr. Eccles by his house surgeons, past and present, he ran over in his delightful way the main landmarks in his eventful life, and we cannot do better than mention some of these as a permanent record of so notable a career.

Two blots can be found on Mr. Eccles's otherwise scrupulously clean sheet: He did little work at school, and he nearly failed in Physics at University College. He made up for this last, however, by winning his first Gold Medal—for Chemistry.

It was, however, when he entered this Hospital in 1885 that he met with real success, winning the Harvey and the Bentley, and a Gold Medal for Materia Medica. He qualified in 1890 and went on to M.B., B.S., F.R.C.S., and the Gold Medal in the M.S. examination. After becoming Assistant Surgeon at the West London Hospital he won the Jacksonian Prize, became Demonstrator in Anatomy and Operative Surgery at this Hospital, and 1903, thirteen years after qualifying, became Assistant Surgeon to Mr. Bruce Clarke. Nine

years later he reached the Senior Staff; since then his Assistant Surgeons have been Mr. Etherington Smith, Mr. Harold Wilson and Mr. Girling Ball.

As an Examiner in Anatomy for the Conjoint and Fellowship and for the Cambridge and Conjoint Surgery his efforts were very far-reaching. Like all great men he has been considerably libelled in verse; the second verse of one of the best examples which we publish is:

"By faith which, according to rumour,
Large mountains has cast into seas,
He removes an abdominal tumour
With simply ridiculous ease."

His long association with this JOURNAL, both as member and then Chairman of the Publication Committee, makes us want to give a prominent place to this account of his departure. We understand that this is in no sense a retirement; his work in private will continue unabated, and then in the Hospital we shall hope to see and hear him at consultations.

* * *

The death of Mr. Basil Lang, an obituary of whom we publish on another page, must be noted here also as having a special meaning, in that he originated the idea of *Round the Fountain*, the fourth edition of which is now on promotion, a fact which is mentioned in the attractive notice of this edition which appeared in the *British Medical Journal* a few weeks ago.

* * *

We have been asked to include the following announcement:

CONFERENCE ON RHEUMATIC DISEASES.

A Conference on Rheumatic Diseases is to be held at Bath on Thursday and Friday, May 10th and 11th, 1928. Sir George Newman, Chief Medical Officer of the Ministry of Health, has kindly consented to act as President of the Conference. There will be three sessions: (1) Social Aspects, presided over by Lord Dawson of Penn, (2) Causation, presided over by Sir Humphry Rolleston (Regius Professor of Physic, Cambridge), and (3) Treatment, presided over by Sir E. Farquhar Buzzard (Regius Professor of Medicine, Oxford). The local Hon. Medical Secretary is Dr. Vincent Coates, 10, Circus, Bath.

* * *

We congratulate Sir Thomas Horder on being given the Freedom of Shaftesbury, which has only one other Freeman on the roll.

The Warden requests us to state that the closing date for applications for House Appointments in May is 12 noon, Saturday, February 18th, 1928.

* * *

The Hunterian Oration will be delivered on Tuesday, February 14th, by Sir H. J. Waring, M.S., F.R.C.S., and the Arris and Gale Lecture on the preceding day by Adolphe Abrahams, M.D., M.R.C.P., on "The Physiology of Violent Exercise in Relation to the Possibility of Strain."

* * *

Prof. Sir Humphry D. Rolleston, M.D., has been appointed to represent the University of Cambridge at the celebration on May 14th-18th, 1928, by the Royal College of Physicians, of the tercentenary of the publication of William Harvey's book, *De Motu Cordis*.

* * *

Lord Dawson of Penn gave the Abernethian Society an extremely interesting address last week on "Those other Practitioners." His well-balanced phrases, commented on by Dr. Geoffrey Evans, who proposed the vote of thanks, are well worth publishing, and will appear in our next issue.

OBITUARIES.

SIR DYCE DUCKWORTH.



WE regret to announce the death of Sir Dyce Duckworth on Friday, January 20th, at his residence in Grosvenor Place at the age of 87. The following is taken from the *Times*:

Sir Dyce Duckworth was born on November 24th, 1840, the youngest son of Robinson Duckworth, of Huddersfield, and Elizabeth Forbes, daughter of Dr. Nicol, of Stonehaven, N.B. He was educated at the Royal Institution School, Liverpool, and afterwards at the University of Edinburgh. In 1861 he came to London with an introduction to Sir James Paget, and in the following year he returned and served as a clinical clerk at St. Bartholomew's Hospital under Sir George Burrows. In 1863 he graduated M.D. at Edinburgh with honours and the gold medal, and was appointed

Resident Physician to the Clinical Wards at the Royal Infirmary.

He entered the Royal Navy as an assistant surgeon in 1864, but never served afloat, for while he was at Plymouth, Dr. Kirkes, Medical Tutor to St. Bartholomew's Hospital, died, and Duckworth was appointed to succeed him in this important post. He settled in London and shortly afterwards was appointed Physician to the Royal General Dispensary, where he had Sir William Selby Church as his colleague. In 1867 Church and Duckworth were elected Assistant Physicians at St. Bartholomew's. In due course Duckworth became full Physician, holding the office for 22 years, until he resigned in 1905 on attaining the age-limit of 65, and was immediately appointed Consulting Physician to the Hospital.

The high estimation in which Duckworth was held by his fellow Physicians was shown by his appointment as Treasurer of the Royal College of Physicians as early as 1884, and this post he retained until 1923, when he was appointed Emeritus Treasurer. Indeed, at the Royal College of Physicians, Duckworth filled every honourable position to which he could be appointed except that of President. He was the representative on the General Medical Council from 1886 to 1891, representative governor at the University of Liverpool, Senior Censor, Harveian Orator, and an examiner in medicine, while as a member of the Board of Management of the Conjoint Examining Bodies of the Royal Colleges of Physicians and Surgeons he did much to improve medical education in this country. From 1890 until 1901 he was Honorary Physician to King Edward VII when Prince of Wales. In 1886 he received the honour of knighthood, and in 1909 he was created a baronet.

Duckworth devoted his attention more especially to gout and rheumatic affections of the joints. He practised with much success at 11, Grafton Street, Piccadilly. He was a good example in modern times of the old courtly physician, somewhat formal in manner, soft-spoken, rather slow, but easily kindled to wrath, for he did not suffer fools gladly. He was transparently honest, an excellent teacher, and a sound consultant. Honours came to him unsought from many quarters. He was President of the Clinical Society of London from 1891 to 1893, and was medical referee to the Treasury and to the Pensions Commutation Board from 1904 to 1910. He attached himself early to the Order of St. John of Jerusalem, of which he was a Knight of Justice and an Almoner, and he took an active part in the work of the medical Guild of St. Luke. He was for some years Chairman of the Royal British Nurses' Association, and throughout his life he was a champion of the nursing profession.

Sir Dyce Duckworth was twice married. By his first wife he leaves an only son, who succeeds to the title, Mr. Edward Dyce Duckworth, formerly a judge of the High Court at Rangoon.

MR. BASIL LANG.

Many of us will feel that we have sustained a personal loss in the death of B. T. Lang.

His was a very prominent personality, so that since he first came to the Hospital from Cambridge in 1902 he has been well known by successive generations of Bart.'s men. Perhaps his outstanding characteristics were his great good nature and his versatile ingenuity. It gave him real pleasure if he could assist anyone in any way, and those who knew him best will be aware to what trouble and pains, and often to what expense, he would go, in helping those to whom he felt he could be of assistance.

His special bent was things mechanical, and in this direction he showed extraordinary ingenuity, which almost amounted to genius. Anything in the way of a gadget gave him the greatest possible joy. He would grasp its working instinctively, and immediately proceed to dissect it to see in what way it could be improved.

I remember on one occasion when he was in the "House" going into his room and finding him with his coat off, in a sulphurous atmosphere, practising revolver shooting, the target being an out-of-date *Medical Directory*. The real joy of the game was the fact that it was a new revolver which came to pieces, as he explained, in two movements, and in almost as few seconds.

The war provided opportunities for his adventurous spirit, and he was very soon to be found in France in charge of the first travelling X-ray equipment. As the war wore on he filled many positions, and on one occasion he told me that up to date he had lived in thirty-two different messes. In due course he was appointed to an ophthalmic post, and afterwards did none but eye work. This, however, did not mean that his energies were at last to be harnessed, for sometimes, to the chagrin of his colleagues, who were left to carry on, he would disappear in the middle of the morning, not on account of any bodily indisposition, but in order (as it afterwards turned out) to fix some rubber soles on to one of the Sisters' shoes, or to mend the "Flamme bleu" stove. On a winter's morning one of the radiators in the Theatre had burst from frost, and he usurped the post of plumber with results that were astonishing, and which were not limited to his personal appearance. During this time

he invented a range-finder for anti-aircraft, which was adopted by the War Office.

Whilst in France he developed some form of myocarditis, for which he was temporarily invalided home, and from which it is doubtful whether he recovered completely; and it seems more than likely, from what Dr. Canti has told me, that this was an important factor in the fatal termination of his pneumonia.

After the war he settled down to serious ophthalmic practice, was appointed to the staff of Moorfields, and soon firmly established himself. He set himself to perfect a perimeter and spent much time and energy and money on it. It was a very great improvement on anything which had gone before.

The circle of friends who deplore his premature death will, I fancy, be much wider than he would have guessed.

ST. BARTHOLOMEW'S HOSPITAL GOLFING SOCIETY.

AT the Annual Staff and Students' Golf Match on May 18th, 1927, the St. Bartholomew's Hospital Golfing Society was formed. Sir Charles Gordon-Watson was elected President, and G. Graham and R. S. Corbett Secretaries. H. Carson, C. M. Hinds Howell, C. H. J. Ilott, T. H. Just and C. E. Woodrow were elected to serve on the committee.

All past and present students who are on the Medical Register are eligible for membership. The entrance fee will be five shillings, and a subscription of half a crown will be paid by all those who play in the summer competition.

The first meeting will be held on Wednesday, June 20th.

Sir Charles Gordon-Watson has given a Challenge Cup for the best bogey score under handicap. A four-some competition against bogey will be held on the same day, and supper will be arranged after the meeting if possible. It is hoped that all who play golf will join the Society, and send in their names and entrance fees to one of the Secretaries, c/o St. Bartholomew's Hospital.

INTRA-CRANIAL AEROCELE : COLLECTED CASES.

EXCLUDING air introduced by the surgeon for diagnostic purposes, air within the cranium is usually the result of trauma, especially that which causes fracture of the anterior fossa of the skull. Intra-cranial aerocele is not common. The cases here collected have been found with some difficulty and no doubt other similar cases are on record. Cases of intra-cranial gas formation by bacteria are excluded from this article. Cushing records four cases of orbito-ethmoidal osteomata, two of which showed an intra-cranial aerocele and are detailed here as illustrative cases.

CASE 2 (Cushing).—"Orbito-ethmoidal osteoma, with intra-cranial complications. Convulsions and recurrent orbital infections. Previous lateral craniotomy with drainage of aerocele (? infected). Attempted exposure of tumour blocked by infected frontal sinus. Subsequent surgical procrastination. Nasal rhinorrhœa with ventricular pneumatocele. Death from meningitis four years after onset of symptoms.

Ten years previously, injury to mid-frontal region.

September, 1920.—Pain and swelling in right orbit. Ethmoid cells opened; *nil* found.

April, 1923.—Trepined; frontal lobe punctured. "An accumulation of air and cloudy serum was encountered and evacuated," also "a bony growth, as big as the end of the thumb, inside the skull near the mid-line above the nose." Temporary improvement. Cushing deferred radical operation, because of fatal result of operation in a previous case of orbital osteoma.

October 28th, 1924.—"Right frontal osteoplastic craniotomy. Accidental opening of infected frontal sinus. Radical operation abandoned. Drainage of sinus."

January, 1925.—Rhinorrhœa said to have been present intermittently for the last two years. "On lowering his head he hears (and one can hear with the stethoscope placed anywhere over the head) from three to four sharp metallic sounds, like drops of mercury striking the bottom of a tin pan. On raising and throwing back his head, he hears these three or four sounds repeated. The impression is gained that there must be, somewhere in the skull, an hour-glass-shaped pocket containing fluid with bubbles of air, which pass from one cavity to the other through a narrow neck."

"A series of X-ray films were immediately taken, which showed that the bubble of air was in the cerebral ventricle, and shifted from the frontal to the occipital ventricular horn on change of position."

End result.—Three months later went to bed feeling in perfect health. At 5 a.m. woke with a headache, followed by vomiting. At 10.30 a.m. had a convulsion, and died a few hours later, with a temperature of 106° F.

CASE 3 (Cushing).—"Huge intra-cranial pneumatocele of unexplained origin exposed and emptied at operation. Recurrence of pneumatocele. Second operation, revealing a minute pneumatic sinus alongside an orbito-ethmoidal osteoma. Closure by fascial stamp. Recovery."

Five years previously.—Frontal scalp wound; no suggestion of bone injury.

One year previously.—Headaches, with weakness of right hand, speech, memory, etc.

October 6th, 1925.—X-ray showed running backwards along frontal bone a clear area, 13 cm. long by 5 cm. wide. Also a dense shadow in region of left frontal sinus (? osteoma). No rhinorrhœa, no succussion, no evidence of fluid in cyst.

November 12th, 1925.—Large left osteoplastic flap. Brain over cyst bulging, rather avascular and yellowish, sharply differentiated from adjacent normal brain. The appearances were those of a gliomatous cyst covered by a thin layer of cortex. The cyst was punctured and air escaped, leaving an enormous cavity. Inspection of cavity showed no fluid and therefore no connection with the ventricle. The walls of the cyst were composed of naked white nerve-tissue, with no sign of a lining membrane. The cyst cavity was pear-shaped, and ran down to a narrow neck as shown in the skiagram. The cyst was filled with Ringer's solution, the dura was sutured, the bone flap was replaced and the wound was closed without drainage. Excellent recovery. Skiagrams taken four, twelve and nineteen days after operation showed no air in the cyst.

January 6th, 1926.—Eight weeks after operation; skiagram showed the cyst to contain air and fluid (Ringer's solution).

Seventeen weeks after operation the cyst contained more air and was larger.

Second operation, March 25th, 1926 (eighteen weeks after first operation). "Re-elevation of former flap. Extra-dural exposure of orbito-ethmoidal osteoma projecting through dura. Removal of intra-cranial projection of tumour. Disclosure of minute canal connecting ethmoid cells with the adherent lepto-meninges, whereby the pneumatocele could be inflated. Fascial implantation. Recovery."

The connection of the cyst with the nose was proved by compressing the nose during respiration, when a bubble of air emerged from the minute channel. A piece of

fascia, 3 by 2 cm., from the patient's leg was placed between the base of the frontal lobe and the opening of the narrow channel. The bone-flap was replaced, leaving an extra-dural cavity, filled with air, between the collapsed frontal lobe and the bone. The head symptoms disappeared at once and recovery was sound.

Skiagram ten days after operation showed small amount of air still present. Skiagram twenty days after operation showed absorption of air to be complete.

Cushing refers to a collection of 50 cases of traumatic intra-cranial aerocele, in one of which the aerocele had opened into a lateral ventricle. He advocates operation from above, by large osteoplastic frontal flap, as the only route by which the orbito-ethmoidal osteoma and the track between the nose and brain can be dealt with effectively.

Traumatic subdural pneumatocele, with air in both lateral ventricles; recovery.—N. W. Green.—In a patient who had received a blow on the head, a skiagram showed air in both lateral ventricles, most in the left, with a large subdural pneumatocele.

Four weeks after injury.—The frontal bone was trephined, and the subdural pneumatocele aspirated. Saline solution, injected into the pneumatocele, escaped into the naso-pharynx. For four weeks after operation there was rhinorrhœa; eight weeks after injury, succussion was noted in the head.

Skiagram two and a half months after injury (*i. e.* six weeks after operation) showed that all the air had been absorbed.

Sixteen weeks after injury the patient was well.

In the discussion on Green's case, Elsberg recalled a similar case seen one year previously. There was air both in the cranial cavity and in the ventricle. Except some local swelling, there were no symptoms after the injury.

Traumatic intra-cranial aerocele; immediate operation; cerebro-spinal meningitis; death on eighth day.—Recorded by Sir William Wheeler.—The patient fell on his right forehead, sustaining a small wound. He was conscious, but mentally confused. Blood-stained cerebro-spinal fluid trickled from his nose. On opening the skull over the right frontal lobe "air bubbled out in small quantities, followed by blood-stained cerebro-spinal fluid."

Autopsy.—The fracture extended through the right side of the ethmoid and involved the sphenoid. A probe, passed through the fracture, emerged from the anterior nares.

Wheeler quotes Grant (of Philadelphia) on "Traumatic Intra-cranial Aerocele" as follows: Grant collected 10 recently recorded cases, and finds that compound fracture of the skull, involving nasal sinuses, is

the commonest cause of the condition, but any compound fracture, with a dural tear, whether the nasal sinuses are involved, or not may be followed by intra-cranial aerocele. The air is always intra-dural. "The literature on the subject suggests that, owing to the danger of infection in these cases, the presence of aerocele, immediately following injury, is an indication for operation, and Grant thinks that an attempt should be made to close the dural tear. If five or six days have elapsed, and the aerocele is discovered in a photograph by accident, the sinus may have spontaneously closed, and the policy of watchful waiting for absorption should be instituted." In 6 of the cases the aerocele developed insidiously, and was found by X-rays at intervals varying from a few days to several months after injury; in some cases the injury was comparatively trivial."

In 4 cases no operation was performed. Of these, 2 recovered and 2 died—one six months after injury. Of the 6 cases operated upon, 2 recovered and 4 died; "in one a cyst containing air the size of a hen's egg was found and three succumbed to meningitis."

COMMENTS.

(a) Fractures of the anterior cranial fossa are not uncommon, may be caused by small degrees of violence and may be unsuspected. Of cases which survive the immediate results of the fracture, the majority remain permanently free from intra-cranial complications. A small minority develop, at intervals of a few weeks to five years or more after the injury, (1) rhinorrhœa (escape of cerebro-spinal fluid), (2) intra-cranial aerocele, (3) orbito-ethmoidal osteoma (possibly excess of callus at the site of the fracture). Cushing records 4 cases of osteoma, 2 of which had complications (1) and (2).

(b) The factors which result in a sinus, connecting the lateral ventricle, etc., with the cavity of the nose, are not fully understood. Cushing believes in the formation of an aerocele, which later ruptures into the ventricle. Cases of spontaneous cerebro-spinal rhinorrhœa are said to occur, but, with bones so thin as those of the anterior cranial fossa, pre-existing bone disease, polypi, etc., especially if treated by operation, could easily explain a small perforation of the bone. That cerebro-spinal fluid should suddenly begin to escape through bone which has never been the subject of injury or disease is highly improbable.

(c) The intra-cranial air may be (1) subdural, (2) in the substance of the brain, (3) in the lateral ventricle, where the mixture of air and fluid may cause the sign of succussion, or (4) in a combination of any of these sites.

(d) Intra-cranial air, *per se*, is not dangerous, being absorbed in a few weeks. The danger to life lies in the possibility of intra-cranial sepsis, which may occur years after the original injury. So long as there is an escape of cerebro-spinal fluid, or a repeated re-entry of air into the skull (shown by failure of the aerocele to disappear by absorption), the risk of meningitis remains. Both the air and the infecting bacteria usually enter from the nose through a persisting opening in the fractured anterior fossa. A point in the treatment of cases known to have a communication between the cavity of the nose and the intra-cranial contents is to prohibit all nose-blowing, and, as far as possible, to avoid sneezing and coughing, or anything which tends to raise the pressure of the intra-nasal air.

(e) *Treatment.*—An aerocele, discovered during the first few days after injury, unless there are other indications for operation, is probably best left alone. When, after many weeks, either the cerebro-spinal rhinorrhœa or the aerocele is still present, the question of operation has to be considered. Grant and Cushing are agreed that, in these late cases, the indication is to close or shut off the opening leading from the nose to the brain. In 2 cases Cushing has done this and saved the patients. A very large osteoplastic frontal flap is made and the floor of the anterior fossa exposed by elevating the frontal lobes. If an osteoma is present, it is either partly or wholly removed. The opening into the nose is demonstrated and closed by laying over it a piece of fascia, about 1 in. square, taken from the patient's leg. The fascia lies between the bone and the frontal lobe. Cushing is certain that the only effective approach is through the skull by a large osteoplastic flap. The operation may be very difficult, and should be undertaken only by an expert in cranial surgery.

REFERENCES.

- CUSHING.—*Surgery, Gynecology and Obstetrics*, June, 1927.
 GRANT.—*Ibid.*, February, 1923.
 GREEN.—*Annals of Surgery*, lxxv, 1922.
 WHEELER.—*Lancet*, March 17th, 1923.

C. HAMILTON WHITEFORD.

ALCOHOLISM.

THE habit of taking alcohol to excess can most easily be looked upon as the symptom of some form of mental illness. It is only when the habit has been established for a number of years that it comes to be a disease in itself. Alcoholism, in either stage, must be considered as a definite illness.

There is a tendency to look upon unrestrained excess in alcohol as something for which the patient should be held to blame, and from this attitude arises that tendency to social ostracism of the patient which makes the condition in its later stage more difficult to cure.

To understand the originating cause of such a symptom as alcoholism it is necessary to consider some of the causes which are liable to give rise to mental ill-health.

For the civilized man life is a constant strain between two contending forces. On the one hand, his primitive wishes are trying to gain expression, and on the other hand, are his social ideals, which hold these in check.

Of his primitive wishes, only three need be considered: these are the instinct of self-preservation, the instinct of reproduction and the instinct to protect his own property.

The activities that arise when these instincts are aroused are checked by the training towards a state of civilization which occurred in the early days of the man's education. The result of this training is to check the expression of the instinct at some level of the mind below consciousness, so that in the completely civilized adult there is a complete unawareness that the instinct has been stimulated at all, and, although perhaps no one ever attains to this perfection of civilization, yet a large degree of this control is necessary in order that the individual may live with his fellow men.

These instincts are aroused in many different ways. They are stimulated constantly in a small degree by the ordinary conditions of life. It is not suggested that the stimulus is sufficient in such cases to arouse the emotions associated with these three instincts in their full degree. Terror, sex and rage are seldom aroused in civilized circumstances, but a smaller stimulus than would produce these extreme emotions, if it is occurring frequently, will produce quite sufficient disturbance of the mind to lead to the need for some response to the stimulus and for some activity, which is probably being denied by the social ideals to which the individual has attained.

These activities must find their outlet in some other direction, or, failing this, some means must be adopted to prevent the irritation to the motor cortex to which this stimulus gives rise.

When a man consults his doctor for this condition the restlessness is easily controlled by some drug, such as potassium bromide, but when the patient takes the matter into his own hands he may find relief in the narcotic effect which a certain dose of alcohol produces. Putting this in ordinary lay parlance, it means that a man takes alcohol to drown his troubles.

It would be of advantage to study for the moment the mechanism that is set in motion when one or other of the instincts is stimulated. They are stimulated by different means in the case of each instinct, but the result of the stimulation in the case of all three of the big emotive forces is very similar.

The instinct of self-preservation is aroused by anything sudden, anything unexpected, and anything that is not understood. The instinct of reproduction is aroused by the presence of a possible mate, and the instinct to protect our own property is aroused by the presence of anyone who threatens any of our possessions, so that it includes the maternal instinct and such social aims as the wish to preserve unharmed an ideal or a political opinion.

The result of the presence of any of these stimuli is to produce motor activity as one of its manifestations, because primitively and in lower forms of life than man, all these instincts are followed by a physical response. The self-preservation instinct is followed by running or whatever the method of escape may be; the reproduction instinct is followed by a pursuit or a display, and, possibly, by a physical contest to overcome the reluctance of a mate; and the instinct of protection would naturally be followed by a fight.

It should be observed that the conscious mind does not originate this activity, because it takes its origin in the mid-brain, and reaches the motor cortex secondarily, so producing a stimulation of the motor activity, without the intervention of any conscious effort. This can be demonstrated in many different ways and its truth must be accepted, a description of the methods of proof being outside the scope of this article.

The only part played in the mechanism by the conscious mind is that of controlling the outward manifestations of the physical activity that is being aroused. That is to say, that although a soldier in the trenches would have his self-preservation instinct stimulated by the bursting of a shell and he would be prepared for running away, yet he is prevented from taking that action by the conscious control which he has gained as a result of education, the teaching of discipline, and, possibly, by the knowledge that he would be shot if he responded automatically to the preparation for escape that has occurred in his body.

Some use must be found for the energy if the subject

of the stimulus is to remain peaceful and healthy. The same rule applies to the activity that is aroused when either of the other instincts are stimulated, and one of the greatest difficulties with which civilized man has to contend is the problem of how to utilize the motor activities aroused when the primitive instincts are stimulated.

When this occurs at long intervals, recovery can be found through the natural energies of everyday life. These utilize and employ the activities, and, in fact, it can be said that all the energies which we display in our everyday lives have this source and origin.

When, however, this stimulus is frequent or continuous, even if the degree of activity is not very great on every occasion, so long as it produces in its sum more energy than can be used in everyday life, then that energy will be a burden which the whole mental and physical system supports with difficulty. It is this factor which gives rise to so many of the symptoms that are usually recognized as "nervous" and produce the anxiety and emotional states for which these patients seek advice.

Up to this point these stimuli and the conditions to which they give rise have been dealt with as being simple, straightforward and direct, but as a rule these stimuli are much more subtle in their effect and their origin is much less easily recognized. This part of the subject can now be profitably considered.

Civilization is the result of training. As individuals we are civilized with difficulty, and our opposition to the civilizing influences is due to the fact that these influences offer an opposition to the natural expression of our primitive wishes.

To the primitive man the formation of a herd or tribe, of which he became a member, was necessary so that he might enjoy the protection which life in a community affords. A number of people living together are better able to defend themselves against enemies, and, by joining together, they can provide themselves more easily with food.

It is, therefore, under the influence of the self-preservation instinct that civilization arises, but the life of the community necessitated at once the control of the other instincts of reproduction and the protection of property. As civilization and the community life became more extensive and complex, the necessity for controlling the expression of the primitive impulses became more pronounced, until a social ideal was developed which was in complete opposition to any expression of the primitive desires.

The prenatal development of man goes through those stages which demonstrate his origin from more primitive types, and at birth he is mentally in the state of a

primitive savage. The civilizing process begins at once, and he is taught to observe all the social rules which will enable him to live in comfort in the class of life for which he is destined.

The effect of this can best be observed by taking a simple example. Let us say that the child is taught the rights of individual property, and that he is taught not to thief. He becomes aware that the attitude of everyone around him is inimical to the expression of the wish to take anything that does not belong to him. If he should break this rule later in his life, he feels afraid, he is uneasy with a feeling of guilt, and he becomes aware of what is known as the "force of conscience."

This is a change in his physical state, and is probably the reappearance of the emotional state belonging to some occasion in childhood when he was detected in the commission of some minor theft. The emotion he feels is fear, and would be exactly the same emotion as he felt when his childish theft was discovered, and when he realized that he was to be punished for the fault. There may be, and probably are, a number of these memories in the experience of everyone. Although he does not actually call to mind the experience, yet he does go through the emotion that belongs to it.

If he has been properly brought up, then these emotional states will be sufficient to prevent him from repeating the theft, and, in the end, would have their effect before the thought of stealing reached consciousness—in other words, he has become an honest man. He would be incapable of cheating at cards, and if he travelled on a railway first class with a third-class ticket he would feel uneasy until he had paid the excess fare. Such a degree of honesty could only be attained by his having gone through some extremely painful experience associated with theft at an early age.

Again, there is the example of a man whose father insisted upon the whole family speaking the exact truth. This man, when he was a boy, was detected by his father in an untruth, and he was compelled to wear for a fortnight a placard on which was written, "I am a liar." The effect of this brutal punishment in after life was to make him excessively truthful, even to the extent of telling their faults to people he knew very little. This was a constant source of distress to him, because when he restrained the impulse he felt a definite physical uneasiness.

This case illustrates the effect of early experiences and training. The same rules will apply to the effects of education in other matters, and if a man is compelled by the circumstances of his life to transgress against some such early training, the effect will be to produce a physical uneasiness or emotion, which, it should be

observed, is in the greatest number of cases the emotion of fear.

As was suggested earlier in this paper, such a continuous excitement of the motor energies of the body will result in the need for either some other expression of the energy, or for some drug which will keep the motor system quiet enough to enable the individual to live comfortably. The taking of alcohol is one such means of achieving this end, as the following case will show:

CASE 1.—Mr. E. O—, æt. 37, one of a family of four boys and two girls, with both father and mother living and healthy. He had no serious illness and was good at games. At seventeen he went into a city office, and soon afterwards began to take more alcohol than he should have done.

His history showed that he was always on good terms with each member of his family. His father was reserved and undemonstrative, and his mother was a woman who left the bringing up of the children to nurses and never encouraged any of them to show her affection. It became a family tradition, of which they were rather proud, that they never showed any emotion about one another. The patient had often wished to show affection to his mother, but he had never allowed himself to do so because of the knowledge that it would be accepted coldly and that he would be repelled. There grew up in his mind the idea that it was wrong to show affection and the impulse was always checked by a feeling of guilt.

The patient married when he was 26 a very attractive girl whose appeal to him was rather physical than mental. The whole of his married life he felt compelled to control his natural affection, and it was only allowed to display itself naturally when he was half-intoxicated. His mental conflict that was thus produced increased his drinking and was a very great handicap in their lives. By the use of alcohol he was able to overcome his restraint and reach a more natural attitude. This produced a feeling of self-blame, and night after night he was in the habit of drinking to excess and going home in a state of helpless intoxication.

CASE 2.—A man, æt. 32, an artillery officer, was cashiered and degraded during the war for drunkenness. He had been previously in the Regular Army and, while in India with his regiment, at the age of 21, he had fallen in love with his colonel's wife, who had been gratified by his attention, but had never given him any affection in return. It had been his practice after visiting her to go to the mess and to take alcohol until his excitement was overcome by the effects of the drug. He was obliged to leave his regiment, and obtained a transfer into an Indian regiment, but he had by this

time found in alcohol a means whereby he could avoid facing any difficulty, with the result that eventually he was obliged to leave the Service altogether. He rejoined during the war, only to be, as stated above, cashiered for drunkenness.

These cases illustrate the way in which alcohol is used by the patient to overcome the feeling of wrongdoing, or to keep in check the disturbances that arise in the motor mechanism of the body when some emotion is being constantly aroused. It was well known that during the war the taking of alcohol saved many a man from breaking down in the trenches, enabling him to retain his courage, and controlling the activity which was aroused by his subconscious wish to run away from the danger. The greatest number of these men ceased to take alcohol when the strain was over, but it had this danger: it taught them that alcohol was a means of avoiding difficulty, and when they were subjected to other strains of a similar nature after the war, the most natural action was to have recourse to the use of alcohol again.

It is not necessary to describe the effect of a prolonged use of alcohol. It lowers the capacity for standing up to mental strain by offering a ready means of escape, and it renders its addicts less effective and less capable for that reason alone. The mental degeneration that occurs in such cases is partly the result of this use of alcohol. Apart from this the distress which is caused to the alcoholic by the knowledge that he is behaving foolishly, living inadequately and distressing and disappointing those who are fond of him is very great, and this, in its turn, leads to the taking of alcohol and the formation of a vicious circle. Later in the course of the illness comes the effect on the whole of the body of the poison of alcohol, causing degeneration of the nervous system, of the digestive tract, and of the whole body generally. These effects are well known, and are only of interest in this paper from the point of view of prognosis, the recoverability of the patient being dependent on the degree to which the body of the patient has degenerated from the poisonous effects of the drink.

Treatment.—The treatment of alcoholism offers as a rule no greater difficulty than is to be found in the treatment of other mental diseases, and it should be approached in the same way. There is a tendency on the part of those surrounding the patient to hold him blameworthy for the condition in which he finds himself. It should be the object of the physician to combat this idea, and to make the patient realize that he is suffering from an illness which can be cured. It will be found that instead of producing in the patient's mind the idea that he might as well go on drinking

because he cannot help it, it does in fact assist him to take a new attitude towards his life, and gives him the hope that he may indeed be able to recover, and live his life in the same way as those who have been ready to blame him in the past. Alcohol must be forbidden, and any slight relapse on the part of the patient must be discussed with him sympathetically and understandingly. Such a relapse may give a clue to the cause underlying the condition.

ERNEST SNOWDEN.

(To be concluded.)

A CASE OF ACUTE PANCREATITIS.

ACUTE pancreatitis is a comparatively rare disease, the average number of cases admitted to this Hospital being probably not more than two during the year. It belongs to the category of the "acute abdomen," and, like a perforated viscus, is manifested by the sudden onset of pain.

The ordinary text-book of surgery is not very illuminating on the question of diagnosis, but the condition has been very lucidly described by Sir Holburt Waring in conjunction with Mr. H. E. Griffiths, who have reviewed a series of fifteen cases in vol. xi of the *British Journal of Surgery*.

From the series they deduce certain typical signs and symptoms which may be present in cases of acute pancreatitis. These are as follows:

- (1) Acute sudden epigastric pain.
- (2) Vomiting.
- (3) Lax abdominal wall in contra-distention to rigidity.
- (4) Temperature at first subnormal, rising to 101°-102° F. Pulse at first rapid and weak.
- (5) Cyanosis and jaundice.
- (6) Localized abdominal swelling.
- (7) Raised diastase content of urine.
- (8) Positive mydriatic test (Loewi's test).
- (9) Glycosuria.

Zackary Cope especially emphasizes the absence of rigidity as being a characteristic feature of the disease, as rigidity was at one time thought to be the rule. It is interesting to note that out of Sir H. J. Waring's and H. E. Griffiths's series, 13 had a lax abdominal wall.

The average age of the patient is about 50 years, while males suffer as commonly as females.

The case about to be described is atypical in many respects, although it is agreed that the signs and symptoms of this disease are very variable.

Mrs. Elsie K—, æt. 27, a domestic servant, was

admitted to Harley Ward on the evening of November 7th, 1927, complaining of abdominal pain. She gave the following history: She had been ill for five days. On November 1st she had been out in the evening in the rain and had got wet, but did not trouble to change her clothes on returning home. She sat in front of the fire, and later went to bed feeling "creepy." Next morning she was quite well and made herself a cup of strong tea. Following this she felt faint, and half an hour later was seized with abdominal pain. The pain was severe and numbing in character, situated in the epigastrium.

She lay down for a while, which brought relief, but on rising she still felt dizzy, but not sick. This gradually passed off, and in the evening (November 2nd) consulted her panel doctor. She slept well that night.

While carrying out her domestic duties next day she again felt suddenly dizzy, with the sensation that "all her inside had dropped forward as well," which was unassociated with pain. The dizziness continued for a while on attempting to move about. The attacks of giddiness continued all that day, very little food having been taken since the first onset.

Next morning (November 4th) suffered with intermittent pain in the left side of the abdomen—"sharp, like a knife." Pain relieved by medicine prescribed by her doctor. No marked change till November 6th, when at 2-3 a.m. she was awakened from her sleep by severe pain in the lower half of the abdomen. She felt faint, and believed that she actually fainted for a period. During the ensuing hour she vomited several times, and she passed a sleepless night, while the pain was continuous up to her admission. Vomiting did not persist, but was replaced by flatulence. No further giddiness or epigastric pain.

At no time was there any pain in the back or shoulders; no pain or difficulty in micturition; no jaundice observed. Previous to admission the bowels had been confined for three days. The menses were quite natural and regular.

The patient presented the following features on examination: Pulse, 110; temperature, 97.6° F.; respirations, 28. She looked very ill, pale, but not jaundiced or cyanotic; complaining of great thirst; tongue was slightly furred, but not dry. Heart and lungs were normal. The abdomen was distended, tympanic and everywhere tender, excepting the flanks, where there was shifting dullness. The abdomen felt curiously "doughy." No loss of liver dullness; no visible peristalsis. *Per rectum*: The rectum was ballooned; no fæces; not tender. *Per vaginam* there was a doubtful resistance in the right fornix. Reflexes normal. A specimen of urine could not be obtained.

Immediate operation was decided upon, the diagnosis of general peritonitis secondary to appendicitis or salpingitis being made.

Exploratory laparotomy was performed by Mr. Alex. E. Roche: The abdomen was opened through a right paramedian subumbilical incision, revealing the peritoneal cavity distended with clear, blood-stained fluid. There was no gas, pus, clots, flakes of lymph or food. Examination of the lower abdomen revealed normal appendix and pelvic organs, while the bowels were not distended. The great omentum, however, was studded with minute yellowish-white nodules, the size of millet-seed. Two of these were removed for examination.

On palpation of the upper abdomen adhesions were felt in the region of the spleen, the liver and kidneys being normal. The pancreas was not felt to be enlarged in the mid-line. No sign of perforation could be seen in stomach or duodenum, but in the region of the pyloric end of the stomach, lying apparently below it, was an area measuring about 2 in. by 2 in., bulging forward. This was yellow in colour and of a trabeculated, gelatinous consistency.

At this stage the patient became almost pulseless; accordingly a tube was passed down to the pelvis and the abdomen closed with all haste.

The patient rallied from the operation and has progressed smoothly towards recovery. The temperature rose for five days following the operation, reaching 102° F., and then gradually settled down. The tube was removed on the second day, drainage seeming to be completed.

The following tests were carried out subsequent to operation:

The urine during the whole period of her stay in hospital was free from sugar, the diastase content being 33·3 units on two occasions. Stools were normal in appearance and did not appear fatty.

Loewi's mydriatic test negative. The peritoneal fluid contained large numbers of leucocytes and red blood-corpuscles; cultures were sterile after three days. The diastase content of the fluid was over 100 units. Sections of the nodules removed from the great omentum had the microscopic appearance characteristic of fat necrosis.

The convalescence was uneventful, and the patient left hospital one month after operation.

Thus it will be noticed that this case conformed to type only to the extent of the abdominal pain, soft abdomen and fat necrosis, while the other signs were conspicuously absent.

I am indebted to Mr. Rawling for his kind permission to report the notes of this case.

C. B. V. TAIT.

THE PINK PAPER: A REVERIE.



REACHED the Hall a trifle late, the numbers
they were done;

The candidates were coming out, in groups,
and one by one.

And so with mingled feelings there I waited in the gloom,
To hear the news of my success, or maybe hear my doom.

At last I found a damsel tall, she traced my name with
ease,

But when I saw her visage fall, I trembled at the knees.
"Alas!" she said, and sadly smiled, "your name in
blackest ink

Is carefully inscribed upon this flaming page of pink."

I took it very gingerly and kissed her finger tips,
Although I should have much preferred to taste her
ruby lips.

I took me sadly homewards where I dreamed of oceans
wide,

With little fairy mermaids crowding round on every side.

The sky was pink, the sea was pink, the shells and sea-
weed too

Were delicately tinted with this same abhorrent hue.
And all were singing lustily a song I loved to hear,
About a little mermaid sweet with epimenorrhea.

And dear old Father Neptune was explaining with his
fins

The latest Dublin teaching on the management of twins.
He handed me his trident and a long and rusty nail,
With which to do a "Cæsar" on a fat and flabby whale.

And all the mermaids crowded round and cheered me
to the skies,

Tho' I couldn't find the uterus—the salt got in my eyes;
Then suddenly they disappeared, the cause was clear to
me,

A huge torrential P.P.H. had washed them out to sea.

I marsupialized the stomach and cauterized the spleen,
That raised a lovely hissing noise and clouds and clouds
of steam.

I made a grand colostomy and decompressed the brain,
And divided the medulla to alleviate the pain.

But now the small intestine, which I'd carefully laid
aside,

Was floating on the ocean; it extended far and wide.

The whale's projectile vomiting was heard above the
roar

Of its waves of peristalsis which were breaking on the
shore.

And poor old Father Neptune, he was screaming mad
with fear
At the roaring borborygmi which were booming in his
ear.
And as I cut the ureters he dealt me such a whack
On my lumbo-sacral junction which put me on my back.

* * *

I found I'd fallen out of bed, my head had hit the door;
The impact was a savage one, it shook me to the core;
And all my lumbar vertebræ were bruised and stiff and
sore,
From hitting *Stevens's Gynæ.* which lay open on the
floor.

F. W. J. W.

AMATEUR DRAMATIC CLUB.

"ASK BECCLES."

Twas a bold venture on the part of the Amateur Dramatic Club to select for their annual entertainment a play which had been so recently seen on the West End stage, and was therefore comparatively fresh in the memory of what was probably a large proportion of the audience. But what it was out to lose on the swings was insignificant to what it certainly made on the roundabouts. For, whatever may have happened to the memories of the audience, those of the cast served them royally, and were at liberty to be refreshed at will by a first-rate touring company in an end of London somewhat further West. In a word the venture was justified. More, it was one of the most finished amateur performances it has been our pleasure to endure. Before the curtain had been up five minutes we settled back with the comfortable realization that here were not "bricks without straw." In fact, the architecture of the plot was such that, but for the exceedingly good quality of the material, the edifice of the play could not have withstood the first puff of criticism. The plot strove to thicken, but without success—till at length its thinness became, at the naïve returning of the stolen diamond, positive emaciation. Assuredly, the play was *not* the thing! But the manner of its presentation made us suffer its foolishness gladly.

The casting was admirable. Eustace Beccles, the happy possessor of a memory which must have turned many prospective visitors to Queen's Square green with envy, was played by Mr. G. P. Roxburgh with a quiet

assurance that looked as though it would gain him his heart's desire before the end of the first act. Indeed, when the saxophone and the golf club had been carefully removed from the field of action and parked in a corner, and there remained nothing but the sofa between him and the lady who, the programme convinced us, must, in the absence of other competitors, ultimately be his, we perched on the edge of our seat in a thrill of expectancy. When, a few moments later, the width of the sofa had dwindled to 3 inches of the thinnest air, we almost over-balanced. Beccles, however, retained his poise, and remembered just in time that there were two more acts to be played first, and apparently decided that Marion, acted with grace and charm by Miss Erica Lodex, was worth waiting for. We entirely agreed.

Miss Leila Alexander's interpretation of the impossible Mrs. Rivers was a gem of character study. If the action of the play ever tended to drag a little, her appearance was a tonic none could resist—we drank it down and clamoured for more. As her unwilling *protégé* Mr. R. M. S. Cross, who might easily and pardonably have given us a caricature of the modern lounge lizard, acted with commendable restraint, and was a lifelike and at times almost a pleasant reptile.

Mr. A. W. Spence as the villain was a nasty bit of work. (This is personal, of course, but also—high praise.) His exit from Beccles' consulting-room was masterly, and seemed to embody the spirit of many of our own "*esprits de l'escalier*." The rôle of Matthew Blaze was more than adequately filled by Mr. J. T. Hunter, who made the most of the infinite possibilities offered by the character of the Jew. Though morally satisfying, his demise was undoubtedly a histrionic loss. The part of Baki, the Hindoo servant, was admirably played by Mr. N. A. King—a careful and clever study. Several minor characters maintained the high standard of the acting, and rounded off a very pleasing performance.

The new stage, while giving more scope to the actors, had apparently refused to accommodate the scenery, and this a few hours before the first performance. New sets were obtained, as by magic, and the play, when we saw it, was capably staged. We congratulate the wizard, Mr. Nicholson, on his achievement.

The Orchestra, under the direction of Mr. Orr, played pleasantly in the intervals,

"That the time might pass more gaily,
And the guests be more contented."

It did, and we were.

A. J. M.

[Photographs of the cast will be published in the next number.]

ABERNETHIAN SOCIETY.

A MEETING of the Society was held in the Medical and Surgical Theatre at 8.30 p.m. on Thursday, November 24th, 1927, Mr. Wroth in the Chair.

The minutes of the last meeting having been read and confirmed, the President called upon the speaker, Prof. HARTRIDGE, to deliver his address on the subject of "Sleep." The following is an abridged account:

The world is so used to regarding sleep as one of the pleasant and regularly recurring parts of the cycle of events which go to make up one day of life, and is so used to taking for granted that sleep is but a means of refreshing the tired body and mind, that ninety-nine-hundredths of its population probably never give the matter a second thought, or seek to find out the causes of its appearance. Apparently Dr. Hartridge is one of the elect of the remaining one-hundredth, and has thus been the means of introducing to us a subject which provides an interesting field for investigation.

Sleep may be said to present symptoms which resemble in many ways those found in certain pathological conditions. Thus some of its typical aspects are met with in diabetic and uræmic comas, in eclampsia, in poisoning with the sulphone group of hypnotics—for example, with trional. Other drugs, such as paraldehyde, morphia, chloral hydrate and bromides produce similar effects. In carbon monoxide poisoning there is inertia, lethargy and insensibility, which in some cases terminates in death.

We do not, in the ordinary course of events, fall asleep spontaneously, but certain conditions of our bodies and surroundings predispose to the production of such a state. Of these conditions fatigue is perhaps the commonest and most generally recognized. After severe daily exercise there is a drowsy feeling which alone, or in conjunction with one or more accessory conditions, such, for instance, as a comfortable arm-chair, a dim light and monotonous low-toned sounds, soon brings about sleep. Again, the state of digestion following a heavy meal, and the taking of alcohol, may assist its onset.

A man about to fall asleep would tell you, if he were questioned, that he had certain feelings. He would say that his limbs felt heavy, that only with difficulty could he move, and that the tendency of his body was to take up a prone position. He would also notice a vagueness of ideas, and inability to concentrate, a feeling of boredom, a desire to be let alone. He would describe a heaviness of the lids, and a pricking sensation of the cornea of the eye. His head, he would say, felt heavy, and his jaw showed a tendency to open involuntarily. He would complain of feeling cold, and of having attacks of shivering.

The observer would be able to confirm many of these symptoms for himself. He would see the nodding of the head, the drooping of the lids, the dropping open of the mouth. If the man talked it would be easy to observe that if he did not actually talk nonsense, at all events his remarks lacked profundity, humour and point. He yawns. On the approach of sleep the respirations become less frequent and consequently deeper, becoming less abdominal and more costal in type.

In sleep the eyes show certain differences from the waking state. The pupils are always contracted—a behaviour which permits of distinction between real and feigned sleep. This contraction has been said by some to be caused by the upward and inward direction of the axes of the eye when asleep, but others declare that the eye axes during sleep may occupy any position. With regard to the circulatory system, we find the blood-vessels partially collapsed and the flow in them slower. The heart itself does not work so hard, its rhythm is slow, and its output per beat small. The blood-pressure falls.

Measurements of the body temperature show the cause of the feeling of coldness and the shivering, because the body temperature is found to be below the normal, sometimes as much as one degree Fahrenheit, occasionally nearly two degrees.

Determination of muscle tone shows that it is abnormally low, reflex actions are hard to elicit, are poorly displayed, and take longer than normal to commence.

During sleep the same depression of the vital functions is displayed; two, however, show enhanced activity, namely, the secretory action of the skin and the processes of digestion. With regard to the former, it is said that the amount of fluid evaporated by the skin during sleep is greater than that evaporated during the daytime, even during severe muscular exercise.

The state of coma of a sleeping man is one of very varying intensity. Suppose that a normal person has the depth of his sleep tested at various intervals after he went to bed; it is found that he is awakened easily just after falling asleep. Soon his sleep is more profound, and greater difficulty will be found in rousing him, until, about two or three hours later, the depth reaches its maximum, following which it decreases till about the sixth hour, after which the intensity of sleep is almost uniform. Just before the person wakes in the morning the depth of sleep increases slightly for a short time, and finally, decreasing, disappears.

Numerous experiments have been performed to test the varying degrees of response to external stimuli during sleep. A delicately modulated musical instrument, with increasingly loud tone, will determine the strength of sound necessary to waken a subject, the sense of touch may be determined by pressure, and that of smell or taste in an obvious manner, during the different periods of sleep.

Only three parts of the mechanism of the body are never rested by sleep. These are the respiratory system, which evidently is indispensable, the heart, and the vascular motor system—that is, the apparatus for the supply of oxygen to the tissues is in constant action all day and all night.

Various theories have been advanced to explain sleep and its attending phenomena. Thus, in 1860, Durham investigated on a dog the effects of sleep on the body processes. In 1881 Mosso did some similar experiments on human beings. The hypothesis which resulted from these investigations was that sleep is caused by a diminution in the blood-supply to the brain, due to (a) the diminished output of the heart, and (b) to the increased flow of blood through skin and viscera. Some confirmation of this hypothesis is obtained in the fainting which follows the cerebral anaemia produced by the abolition of the controlling influences of the central nervous system on the blood-pressure and the taking up of an erect posture. Thus in man and other animals the raising of the head above the level of the trunk is accompanied by a constriction of the blood-vessels of the viscera. The rise of blood-pressure which this produces increases the supply of blood to the brain. In particular the splanchnic nerves may be mentioned as bringing about a constriction of the blood-vessels when they are stimulated. If, however, the splanchnic nerves are cut, these changes cannot take place. The result of such an operation is well shown in the case of a late laboratory cat, which, with severed splanchnic nerve, suffered from an inhibition of the blood-supply to the brain when its head rose much above the level of its body. For this reason fainting fits often occurred, and were cured by the drastic and picturesque remedy of holding it up by the tail to cause an increased flow of blood to the head. Such a state of affairs was too good to last, and the unfortunate cat, after some years, met its fate by its own audacity. For, on trying to climb a long staircase in search, presumably, of a mouse, when no first aid was at hand, it stuck half-way and fainted, thus surrendering at length the last of its spare lives.

Another theory has been that the fall of temperature of the body brings about a corresponding depression in the activity of all body processes, while another claims that the diminished tone of the body muscles is responsible for sleep by causing the temperature to fall, which affects in its turn the rest of the body as before, and causes sleep. Another suggestion is that the changes begin with the heart, and follow the same course as those just given. Two other theories, one histological, the other biochemical, suggest that the sequence begins only at the central nervous system itself. Lastly, some physiologists consider that sleep is just one part of the natural course of events in the life of the body, and, irrespective of outside or inside changes, must come. This is referred to as the "rhythmic theory." It is difficult to decide which point of view is likely to prove most correct, though the first four all have the same fundamental basis, differing only in the opinion as to which organ is the first to begin the events leading up to sleep.

Lastly, it may be asked why we do not consider sleep as a pathological rather than as a physiological condition. A moment's thought would give the questioner a satisfactory answer. Our own experience surely tells us that whereas disease leaves us debilitated and weak, sleep, on the other hand, is the best means of refreshing and resting the body.

The lecturer then dealt with drugs which induce and inhibit sleep, and finished by considering the causes and treatment of insomnia.

The vote of thanks for the very interesting and entertaining address, proposed by Dr. REEVES and seconded by Mr. WOODROW, was carried with acclamation.

In replying, Dr. HARTRIDGE gave examples of the extreme shortness of time during which the action of a dream took place.

The meeting was then adjourned.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. BRADFORD.

Played on January 17th. As usual before our home matches, it began to rain about an hour before the start and continued throughout the game. We were without Gaisford, Jenkins, Bettington, Capper and Briggs, while Bradford had their right wing pair, Roberts and Tetley, away playing for Yorkshire.

The Hospital started off with the wind, and the forwards, heeling well both from the loose and the tight, our backs had many chances of attacking, and within eight minutes Guinness scored from a return pass from Prowse. Shortly afterwards Guinness and Prowse repeated this manoeuvre, but after swerving past the full back, Guinness gave a bad pass inside instead of going on himself. Just before half-time both sides narrowly missed kicking a penalty goal.

The Bradford forwards pressed hard in the second half, but our defence was very sound and never allowed their backs to go far. Taylor broke away inside our "25" and passed to Knox, who was supporting him; the latter drew the full-back and gave Grace a clear run in from half-way, Guinness converting. The condition of the ground was now very bad, and the play was confined to the forwards, while Taylor continually gained ground by his kicking. Just before the end Bonner kicked a penalty goal for Bradford for offside.

Evans at full back had little to do, but saved well from the Bradford forwards on two or three occasions. Prowse and Guinness again proved to be a very good combination on the left wing. Grace had few chances, but ran with determination when he did get the ball, while his defence, as usual, was faultless. Beilby opened up the game with perfect passes and cut through well on occasion, while Taylor can seldom have played better. Often doing the unexpected in attack, he was most useful in getting back to defend. The forwards, although overweighted, held their own, and had more than their share of the ball; Williams was ubiquitous, W. J. Taylor did well in close play, and Knox, playing wing forward for the first time, played an extraordinarily good game.

St. Bartholomew's Hospital, 1 goal, 1 try (8 pts.); Bradford, 1 penalty goal (3 pts.).

Team: W. E. F. Evans (back); A. H. Grace, G. F. Petty, H. W. Guinness, C. B. Prowse (three-quarters); F. J. Beilby, J. T. Taylor (halves); R. N. Williams (capt.), H. D. Robertson, V. C. Thompson, H. G. Edwards, F. G. V. Scovell, J. S. Knox, W. J. Taylor, J. M. Jackson (forwards).

ST. BARTHOLOMEW'S HOSPITAL v. COVENTRY.

January 21st. This game was played at Winchmore Hill on an extremely heavy ground. We have seldom, if ever, seen such a good game in such conditions. Coventry won by the only try scored, though both sides came near to scoring on numerous occasions. Beilby was unable to play for the Hospital owing to an injured knee. The game started at a terrific pace, the back divisions of both sides bringing off several good passing movements. The forwards were doing great work as well, and R. N. Williams led some splendid rushes. Coventry's try came towards the end of the first half, their scrum half getting over from a scrum near our line.

The second half was almost a repetition of the first, except that the ground had become churned up and the going was therefore even more heavy. There was no score in this half, but we had rather more of the play, and had Petty passed as well as he ran and tackled Grace might have scored. The forwards played splendidly, the pack working together as a whole. In the set scrums the packing and heeling were the best we have seen this season, and they brought off many excellent dribbles. All played well, but we noticed particularly R. N. Williams, Robertson and Knox. Taylor at scrum-half played another very good game. The way in which he has adapted himself to this position is a great credit both to himself and to those who thought of playing him here. Guinness was good, but he does not set his three going well. Grace did all he could extremely well, but he was starved. Gaisford played one of his good games, except that he missed the touch-line too often—a sin always, but a crime on a ground such as this game was played on.

The side has come on wonderfully well since the beginning of the season, and is now well equipped in all departments except in the centre of the three-quarter line. With Beilby at fly-half, though, we can have one good centre in Guinness. We consider that every effort should be made to give Grace every possible chance, instead of, at the moment, the fewest possible. Grace is a good wing, and we believe that he will repay the side for playing him.

Team: W. F. Gaisford (back); A. H. Grace, G. F. Petty, E. U. H. Pentreath, C. B. Prowse (three-quarters); H. W. Guinness, J. T. Taylor (halves); R. N. Williams (capt.), C. R. Jenkins, R. H. Bettington, W. M. Capper, J. S. Knox, H. D. Robertson, W. J. Taylor, V. C. Thompson (forwards).
P. G. LEVICK,
Hon. Treasurer.

HOCKEY CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. R.N. (CHATHAM).

The 1st XI commenced the second half of their fixture list by visiting Chatham on January 14th. Unfortunately Attwood, Church and Windle were unable to play, and in addition Sinclair has left the Hospital to do a house appointment at Coventry. Sinclair has for some time been a great source of strength to the team and his loss will be greatly felt. Snell, Iliff, Hodgkinson and Neill came into the side.

The ground proved to be in excellent condition and a fast game resulted, the Hospital giving what was, in the circumstances, their best display of the season.

Playing against a strong wind in the first half Bart's went off at a great pace, and, after a good attacking movement, Francis, playing at centre-forward, opened the scoring. Soon afterwards Hartley, playing at centre-half in this match, scored from the edge of the circle. Chatham now began to do some attacking, and although Bart's still had the best of the game, the score at half-time was 2—2.

After the interval Chatham put in some dangerous rushes to the Hospital circle, but they were slow in front of goal, and with Wright and McCoy getting through a lot of work at back, they failed to add to their score. Symonds and Iliff each scored a goal for Bart's, the latter's effort showing the usefulness of following up on to the goal-keeper when another forward has put in a shot.

The whole team played well, but special mention must be made of the wing halves, Snell and Fordham, who were excellent. The forward line played with method, and Neill, well supplied with passes by Symonds, improved a great deal on his previous displays for the 1st XI.

Team: H. L. Hodgkinson (goal); F. H. McCoy, P. M. Wright (backs); V. C. Snell, K. W. D. Hartley, M. S. M. Fordham (halves); E. J. Neill, J. C. W. Symonds, R. H. Francis, A. D. Iliff, A. G. Williams (forwards).

UNITED HOSPITALS HARE AND HOUNDS.

On Wednesday, November 30th, at Hayes, v. South London Harriers, "A" team. The Hospitals lost by 1 point to a strong team, the score being 27 to 28.

ORDER OF FINISHING.

1. A. W. B. Tebbutt	S.L.H.	29 min. 57 sec.
2. E. P. Raiton	S.L.H.	30 " 25 "
3. E. J. Somerset	King's	30 " 35 "
4. H. C. Harley	St. Mary's	30 " 38 "
5. H. S. Byrne	S.L.H.	30 " 45 "
6. J. S. Horsley	London	30 " 52 "
7. P. Forsythe	St. Thomas's	30 " 55 "
8. H. B. Lee	Bart's	30 " 56 "
9. L. A. Pool	S.L.H.	31 " 10 "
10. C. B. E. Morgan	S.L.H.	31 " 12 "

Points.—South London, 1, 2, 5, 9, 10 = 27.

Hospitals, 3, 4, 6, 7, 8 = 28.

Wednesday, December 7th, v. Blackheath Harriers "A" team. This match was lost by 41 points to 36 at Hayes over the 5-mile course. H. C. Harley (St. Mary's), while leading by about a quarter of a mile, unfortunately took the wrong course.

ORDER OF FINISHING.

1. H. S. Smith	Blackheath	29 min. 30 sec.
2. T. A. R. Callendar	London	29 " 35 "
3. J. S. Horsley	London	29 " 44 "
4. H. B. Lee	Bart's	29 " 44 "
5. J. D. Rogers	Blackheath	30 " 3 "
6. G. J. Richmond	Blackheath	30 " 12 "

Points.—Blackheath: 1, 5, 6, 7, 8, 9 = 36.

Hospitals: 2, 3, 4, 10, 11, 12 = 42.

The 7-mile Handicap will be run on Wednesday, February 1st. Fixtures for February are: 15th, v. Orion Harriers "A" team; 22nd, v. Cambridge University Hare and Hounds.

R. R. RACE, Hon. Sec.

CORRESPONDENCE.

THE TRUSTWORTHINESS OF THE BIBLE.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—We would like to draw the attention of your readers, by a series of letter in your columns, to the evidences of Christianity especially with regard to the Bible on which we, as a Union, base our work.

Yours very sincerely,

St. Bartholomew's Hospital,
London, E.C. 1;
January 20th, 1928.

H. W. GUINNESS,
President.

"What the heart of a fortress is to its outworks and minor defences, that, to the Christian Faith, is the Bible—its central stronghold. To give up that, in any measure, is, therefore, in so far, to yield up the whole fortress to the foe."

"If the Bible be a divine book, it has nothing to fear from rational inquiry. Investigation will issue in vindication, and the more searching the investigation, the more triumphant the vindication."

"God never meant that the believer's confidence in His Word should be a blind bigoted assumption of what is unproven, hiding behind ignorance, tradition or superstition."

"What do you believe?" asked Whitefield of a worker in the coal-pits of Cornwall. "What the Church believes," was the answer. "And what does the Church believe?" "What I believe." "And what do you both believe?" "The same thing."

No! God wants us to use the intelligence He has given us, think out this miracle of books. "For it neither befits nor belongs to the infancy of the race, and yet it was found among men in the early days of the world's history; and, with all the boasted learning and wisdom of the twentieth century, it still defies all competition."

"One of its most important features is its UNITY, which is as marvellous as it is conspicuous. Every circumstance connected with its preparation and production was calculated to prevent such unity. Here are sixty-six different books, written by some forty different authors, in three different languages, and the periods of authorship cover a score or more of centuries. These human writers were brought up in different countries, and were so remote from each other in time and space that they could have had no mutual acquaintance, and could neither have conspired for an evil end, nor combined for the best purpose. The subjects on which they wrote were very diverse and various, some historical, some prophetic, some devotional, some ethical. And yet, notwithstanding all these divergent elements, they have produced essentially ONE BOOK."

"Certain conspicuous conceptions or ideas pervade the whole Book, like golden cords on which all else is strung—such as the ideas of the Kingdom of God, sin and salvation, sacrifice and priesthood. Many of these conceptions are so lofty and unique in sublimity and novelty that it is impossible to account for them on any human theory. They are not the products of the times in which these men wrote, nor are the like found in other literature of those or subsequent periods."

"The unity of the Bible is absolutely unique. Never elsewhere have so many different treatises, historical, biographical, ethical, prophetic, poetical, been combined together, making one book, as all the bones, muscles and ligaments combine in one body."

"What wonder is it if the believer feels that, even considered as a literary product, this Book is Divine."

(See Dr. A. T. Pierson's book, *God's Living Oracles*, Pickering & Inglis, 3s. 6d.)

THIS IS THE BED THAT STALLARD MADE.

[Out of the chaos of criticism evoked by our correspondent's articles, the following is the only reply that can be considered official as having been sent for publication. With the same impartial attitude which made us print that article we print here—the reply.—Ed., *St. B.H.J.*]

This is the cushion that lay on the bed that Stallard made.

This is the air that filled the cushion that lay on the bed that Stallard made.

This is the pump that blew in the air that filled up the cushion that lay on the bed that Stallard made.

This is the window that looked at the back as it lay on the cushion filled with the air blown in by the pump that lay on the bed that Stallard made.

This is the pin that let out the air blown in from the back put in by the pump that filled up the cushion that lay on the bed that Stallard made.

This is the night pro. so scared that she screamed "Oh!" when

she saw the great pin make a hole in the thing and let out the air blown in from the back put in by the pump that filled up the cushion that lay on the bed that Stallard made.

This is the nurse who left her alone while she went to the 'phone to tell the Night Sister she thought 'twas a blister when she stuck in the pin that let out the air blown in from the back put in by the pump that filled up the cushion that lay on the bed that Stallard made.

This is the Night Sister who called up the House Myster to come tend the blister pricked by the pin which let out the air blown in from the back put in by the pump that filled up the cushion that lay on the bed that Stallard made.

This is the trolley, all ready, how jolly, So said the House Myster with aid of Night Sister and strapping of Lister I'll soon mend that blister pricked by the pin that let out the air blown in from the back put in by the pump that filled up the cushion that lay on the bed that Stallard made.

NUF SED and So TO BED.

REVIEWS.

THE SURGICAL TREATMENT OF MALIGNANT DISEASE. By Sir HOLBURN J. WARING. (Oxford University Press: Humphrey Milford.) Pp. 667. 19 Coloured Plates and 277 Illustrations. Price 50s.

"The Surgery of Malignant Disease," by our Senior Surgeon, is a book of outstanding merit, and one which reflects distinction on our Hospital and College.

The Bradshaw Lecture of 1921 forms the basis of the work and acts as an introductory chapter. Although commenced several years ago the whole book has been brought thoroughly up to date, and no recent advances in surgical or scientific work pertinent to the subject have been omitted.

The arrangement of the chapters seems a little curious: the neoplasms of bone are not grouped together, and the liver and gall-bladder are separate from the alimentary system.

The principal pathological features of each condition are described, and an account given of the symptoms and signs with a brief reference to the differential diagnosis. The treatment recommended is in the main operative, especially in all early cases. The possibility of the use of radium is suggested in certain situations, particularly in reducing the size of a growth, as a palliative or a pre-operative measure. The surface application of radium is strongly condemned. The use of deep X-ray therapy is discussed in each section, but the author has formed an unfavourable opinion of this form of treatment. Full statistics are given of the results of treatment, taken from the records of St. Bartholomew's and from the general literature. An unusually full bibliography is given.

A few "terminological inexactitudes" occur. Fig. 98 represents a lymphadenoma, not a sarcoma of the spleen; Fig. 200 a sarcoma of the retro-prostatic tissues. The author does not recognize the spermatogenic variety of carcinoma of the testis, the so-called spermatocytoma, but Fig. 92, described as sarcoma of the testis really illustrates this condition.

The book is exceedingly readable, and the student could well resort to it as a refreshing change from the average text-book. The only dull pages are those devoted to a discussion of statistics.

The publisher is to be congratulated on the production; it is the most profusely and best illustrated book we have seen. Although the price is 50s., which is usually considered to be somewhat excessive, in this instance we have no hesitation in affirming it to be money well spent.

ADVANCED METHODS OF MASSAGE AND MEDICAL GYMNASTICS. By SHIRES and WOOD. (London: Faber & Gwyer, 1927.) Price 5s.

Often in reading a new book on massage and medical gymnastics, one experiences a feeling of disappointment at finding it in nearly all respects except the accidents of wording and expression the counterpart of its predecessors.

To a large extent this must necessarily be so in a book which aims at including in 200 or so pages treatment for all the disabilities and diseases which now come within the sphere of the medical gymnast. A book would be welcomed giving fuller information in the light of experience of one or two special subjects. At the present time, when such a large proportion of cases under treatment are those of rheumatoid arthritis, one looks for some fresh light and help in methods, e.g. in dealing with resultant deformities. Also—for instance, in pes cavus—one always hopes for a new invention in stretching apparatus. But while new methods would be welcomed, perhaps what is more necessary is the presentment of known methods in clear, concise form, with the emphasis stressed on important points. The book under review (while not neglecting new methods,

e.g. the pulley) owes much of its value to its extreme clearness and sense of proportion, its excellent arrangement of exercises in progression and its insistence on fundamental points, which, while known in theory, are not always remembered in practice; for example, the importance of the straight foot in walking for flat foot, the short step in walking after Pott's fracture, the effects of badly-made shoes, the necessity of teaching correct nose-blowing and breathing to the child. It is good to see such necessary prominence given to the science of muscle re-education. The importance of early massage and treatment of fractures in the neck of humerus and Colles's fracture is emphasized.

The chapter on pulley and sling exercises is very interesting, and calls for study with regard to stiff joints, and especially to anterior poliomyelitis.

This book ought to prove of great value to the medical student—who will find the diagrams explain the exercises when medical gymnastic terms might not be understood; to the massage student and also to the advanced masseuse, who has in it an up-to-date, reliable book, on to which she can link the results of her own experience.

EXPERIMENTAL PHYSIOLOGY. By Sir EDWARD SHARPEY-SCHAFER, F.R.S. Fourth edition. (London: Longmans, Green & Co., 1927.) Pp. 139. 92 Illustrations. Price 6s. net.

The fourth edition of this well-known and widely-used handbook quite maintains the excellent standard set by the earlier editions. It may be safely said that the book is indispensable to the student of experimental physiology.

A certain amount of new material is included; in this connection may be mentioned the measurement of chronaxy, which term, one is glad to note, the author Anglicizes.

In one or two instances the descriptions might well be amplified, *e.g.* in the case of colour-vision, and the scope of the book would be increased were more stress laid upon the application of the experiments to elementary human physiology.

It may be mentioned that a stereoscopic microscope is not necessary to observe the circulation in human capillaries; there are on the market several good makes of skin microscope which function admirably, and some of which have been for years in use at this hospital.

If the author had seen his way clear to include in the volume a series of typical tracings obtained in the various experiments, the value of the book to the average student would have been much enhanced, and the incorporation of an index would add materially to facility of handling, both by teachers and students.

DIAGNOSIS AND TREATMENT IN DISEASES OF THE LUNGS. By F. E. TYLECOTE and G. FLETCHER. (Humphrey Milford, Oxford University Press.) Pp. 270. Price 7s. 6d. net.

This is a very practical manual, intended for the "senior student or the young practitioner." The authors have thoroughly succeeded in concentrating on points of difficulty in diagnosis, and have been generous with prescriptions and other hints for treatment that they have found valuable. The book seems most useful where it deals with bronchitis, pleurisy, pneumonia and the like, and is admittedly very sketchy about pathology in general and the rarer conditions. This is compensated for by sound premises and logical reasoning. Points stressed are the importance of a change of air to avoid chronicity after an attack of acute bronchitis or where the discharge from an empyema persists; and the fact that reliance must be placed on no single physical sign, since the advent of X-rays has proved the soundest diagnoses false. The most inadequate part of the book, however, is that dealing with the treatment of pulmonary tuberculosis, and especially with the symptoms of hæmoptysis. The administration of morphia is laid down without any consideration for opposing views. The book is light and very readable.

CHANGES OF ADDRESS.

- BEAGLEY, J. R., "Wood Lawn," Thatcham, Newbury, Berks.
BERRY, Sir JAMES, Bramblebury, Dunsmore, near Wendover, Bucks. (Tel. Wendover 45.)
BRAIMBRIDGE, C. V., The Native Hospital, Mombasa, Kenya.
BROOKE, C. O. S. B., Tuberculosis Dispensary, 6, Glebe Street, Stoke-on-Trent.
BURNE, T. W. H., Chief Surgeon's Quarters, Ipoh, Federated Malay States.
BUTTERY, J. W. D., 1, Grimston Avenue, Folkestone.
DONELAN, C. J., Flat 3, 9, Roxborough Park, Harrow-on-the-Hill.
GILLON, G. G., 70, Wimborne Road, Poole, Dorset.
GOSSE, P., Saville Club, 69, Brook Street, W. 1.
MARTIN, T., Eastgate, Tenterden, Kent.
ROBB, W. A., 25, Harley Street, W. 1. (Tel. Langham 1895.)

APPOINTMENTS.

- BROOKE, C. O. S. B., M.R.C.S., L.R.C.P., D.P.H., appointed Tuberculosis Officer for Stoke-on-Trent.
BURT-WHITE, H., M.D., F.R.C.S., appointed Assistant Obstetric Surgeon to the City of London Maternity Hospital.
DONELAN, C. J., M.R.C.S., L.R.C.P., D.P.H., appointed Assistant Medical Officer to the Surrey County Council.
NOON, C., F.R.C.S., appointed Hon. Surgeon to the Patrick Stead Hospital, Halesworth, Suffolk.
NORRISH, R. E., M.R.C.S., L.R.C.P., appointed House Surgeon to the Royal Northern Hospital, Holloway, N.

BIRTHS.

- BALL.—On January 22nd, 1928, at "Redcroft," West Wickham, Kent, to Harold C. J. and Kate Douglass Ball—a son.
CAPENER.—On December 2nd, 1927, at Ann Arbor, Michigan, U.S.A., to Marion (*née* Clarke), M.R.C.S., L.R.C.P., wife of Norman Capener, F.R.C.S.—a daughter.
DOYLE.—On January 10th, 1928, at 130, Old Bromley Road, Bromley, to Gladys, the wife of Dr. J. L. C. Doyle—a daughter.
EDWARDS.—On January 22nd, 1928, to Eve, wife of A. Tudor Edwards, F.R.C.S., of 20, Queen Anne Street, Cavendish Square—a daughter (stillborn).
GARNHAM.—On January 14th, 1928, at Kisumu, Kenya, to Dr. and Mrs. (*née* Long-Price) P. C. C. Garnham—a daughter.
GILBERTSON.—On December 31st, 1927, at 20, Bancroft, Hitchin, Herts, the wife of Dr. H. Marshall Gilbertson, of a daughter.
HERINGTON.—On December 24th, 1927, to Dr. and Mrs. Cecil Herington, of Ilkeston, Derbyshire—a daughter.
LANDAU.—On December 26th, 1927, at 28, Western Road, Penang, to Marjorie (*née* Gubbay), wife of Dr. J. V. Landau—a daughter.
MALTY.—On January 3rd, 1928, at 56, Rectory Road, N. 16, to the wife of Dr. H. Wingate Maltby, M.C.—a son.
SIMPSON.—On January 15th, 1928, at her father's house, Campden Lodge, W., to Joyce Rayner (*née* Batten) and Reginald Hugh Simpson—a daughter.
YOUNG.—On December 22nd, 1927, at a Bournemouth nursing home, to Olive, wife of S. L. O. Young, M.D., of Wood End, Yarmouth, I.W.—a son.

MARRIAGES.

- BEAGLEY—MASTERS.—On January 4th, 1928, at Budbrooke Church, Warwickshire, James Robert Beagley, M.B., B.S., of Thatcham, Newbury, Berks, only son of Mr. and Mrs. A. Beagley, of 50, Bushmead Avenue, Bedford, to Dora, daughter of Mrs. John Masters and the late Mr. John Masters, of Southam, Warwickshire.
BUTTERY—SMITH.—On January 24th, 1928, at the Oratory, Hagley Road, Birmingham, John Wilfrid Douglas Buttery, late of Durban, S. Africa, to Dorothy Marie, eldest daughter of Dr. Percy Smith, of Edgbaston, Birmingham.
HIGGS—HOWARD.—On December 24th, 1927, at St. James's, Norland Square, Sydney Limbrey Higgs, F.R.C.S., 1A, Portland Place, W., to Betty Howard, 41, Addison Avenue, W., widow of Arthur Howard.

DEATHS.

- DUCKWORTH.—On January 20th, 1928, at 28, Grosvenor Place, S.W., Sir Dyce Duckworth, Bt., M.D., LL.D., F.R.C.P., son of the late Robinson Duckworth, of Liverpool, aged 87.
HINE.—On December 26th, 1927, William Conway Hine, M.R.C.S., of Dunain, Parkstone Road, Poole, Dorset, aged 88.
KING.—On January 17th, 1928, at Croydon, after an operation, Sir George Anthony King, Chief Master of the Supreme Court Taxing Office, aged 69.
LANG.—On January 18th, 1928, Basil Thorn Lang, F.R.C.S., Surgeon to the Royal London Ophthalmic Hospital, Moorfields, beloved husband of Nora Lang, and only son of William Lang, F.R.C.S., of 22, Cavendish Square, W. 1, aged 47.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, St. Bartholomew's Hospital Journal, St. Bartholomew's Hospital, E.C. 1.
The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., at the Hospital.
All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: City 0510.